

MHA MONTANA HOSPITAL ASSOCIATION
Advancing Health in Montana

PIN
Montana Flex
PERFORMANCE IMPROVEMENT IN THE FUTURE

Champions of Quality Improvement Cohort

December 21, 2021

Focus on Root Cause Analysis (RCA)

Welcome! We will begin shortly while everyone gets logged in!

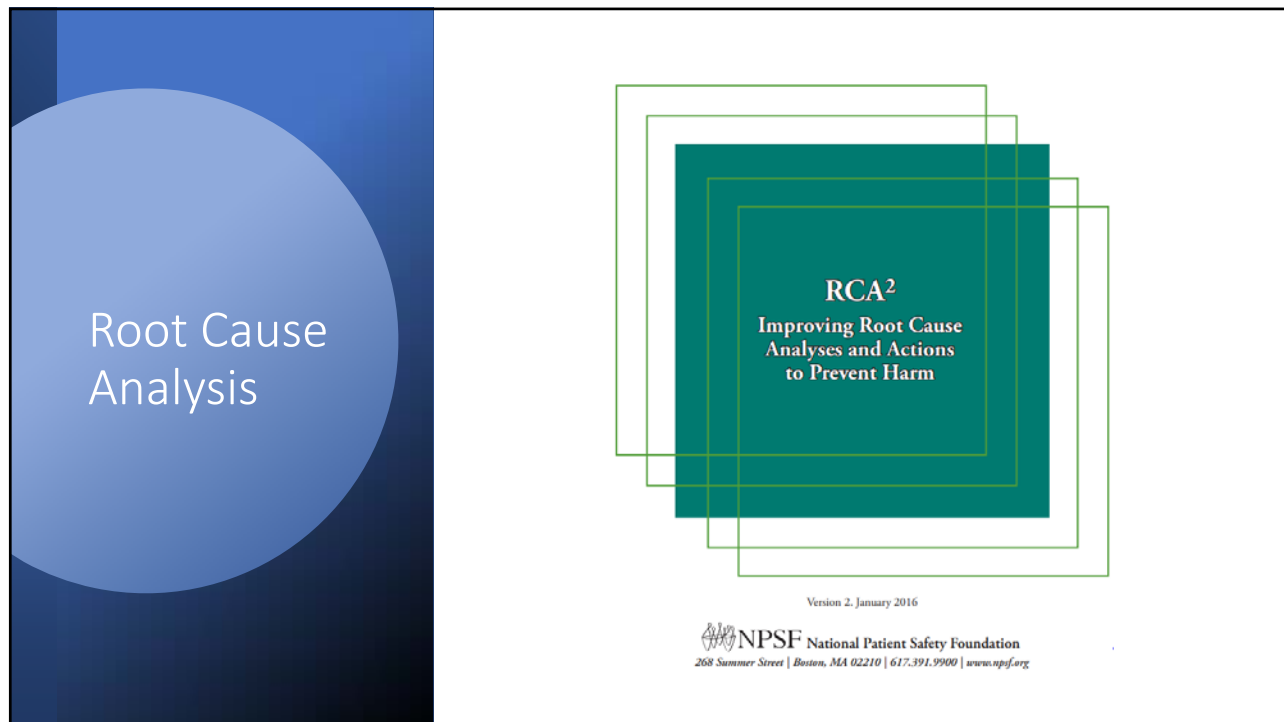
Virtual Roll Call

Name & Favorite Holiday/Winter Treat

Follow Up

Did you try any engagement strategies?

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Rules of Causation (1 and 2)

Rule 1. Clearly show the “cause and effect” relationship.

INCORRECT: A resident was fatigued.

CORRECT: Residents are scheduled 80 hours per week, which led to increased levels of fatigue, increasing the likelihood that dosing instructions would be misread.

Rule 2. Use specific and accurate descriptors for what occurred, rather than negative and vague words. Avoid negative descriptors such as: Poor; Inadequate; Wrong; Bad; Failed; Careless.

INCORRECT: The manual is poorly written.

CORRECT: The pumps user manual had 8 point font and no illustrations; as a result nursing staff rarely used it, increasing the likelihood that the pump would be programmed incorrectly.

Rules of Causation (3 and 4)

Rule 3. Human errors must have a preceding cause.

INCORRECT: The resident selected the wrong dose, which led to the patient being overdosed.

CORRECT: Drugs in the Computerized Physician Order Entry (CPOE) system are presented to the user without sufficient space between the different doses on the screen, increasing the likelihood that the wrong dose could be selected, which led to the patient being overdosed.

Rule 4. Violations of procedure are not root causes, but must have a preceding cause.

INCORRECT: The techs did not follow the procedure for CT scans, which led to the patient receiving an air bolus from an empty syringe, resulting in a fatal air embolism.



CORRECT: Noise and confusion in the prep area, coupled with production pressures, increased the likelihood that steps in the CT scan protocol would be missed, resulting in the injection of an air embolism from using an empty syringe.

Rules of Causation (5)

Rule 5. Failure to act is only causal when there is a pre-existing duty to act.

INCORRECT: The nurse did not check for STAT orders every half hour, which led to a delay in the start of anticoagulation therapy, increasing the likelihood of a blood clot.

CORRECT: The absence of an assignment for designated RNs to check orders at specified times increased the likelihood that STAT orders would be missed or delayed, which led to a delay in therapy.

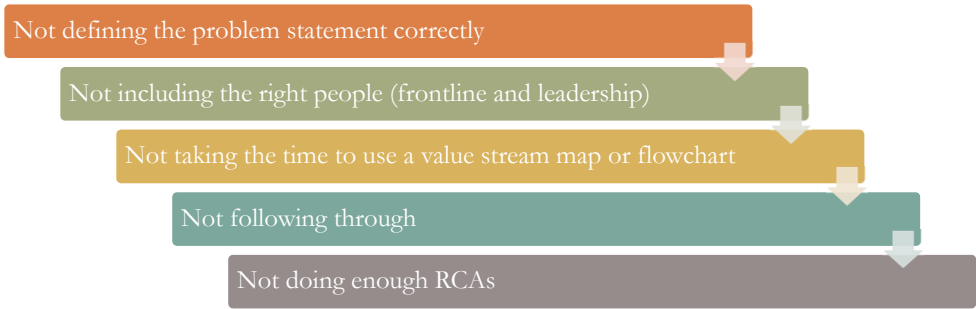


ROOT CAUSE ANALYSIS

Do this, not that!!

Laura Larson-Crismore, Cabinet Peaks Medical Center

Common Issues



- Not defining the problem statement correctly
- Not including the right people (frontline and leadership)
- Not taking the time to use a value stream map or flowchart
- Not following through
- Not doing enough RCAs



Not defining the problem statement correctly

PROBLEM STATEMENT: Medication reconciliation is leading to several adverse events

Really??

What adverse events??
 Minor, Moderate, Severe, Death??
 What time frame??
 Volume??
 How are you rating the importance of these??

TIP: Use your CMS QAPI prioritization matrix to help with rating importance


A better problem statement

Problem Statement: Providers are often skipping the electronic reconciliation portion leading to an increased rate of medication adverse events. **??Can we break this down even further??**

What data can we use to prove this?

- Baseline data from prior year, etc. vs. current year
- Severity of events, increase from last year??
- More providers, new providers, break down by provider
- New leadership? New pharmacist?

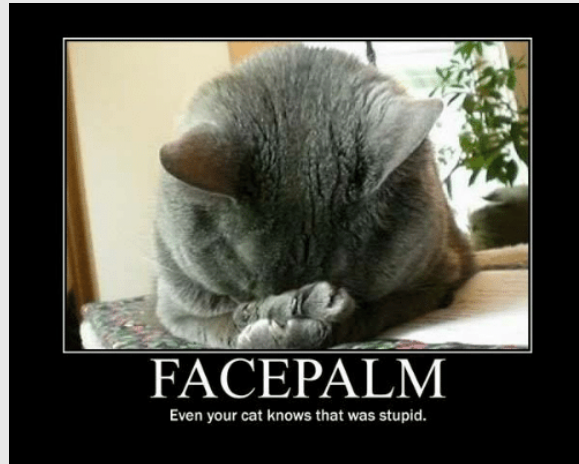
TIP: Prove it!!!!



**But Wait...
THERE'S
MORE!**

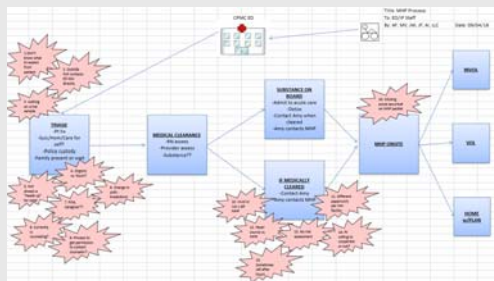
Not including the right people

- Example: bedside rounding
- What could we have done better?

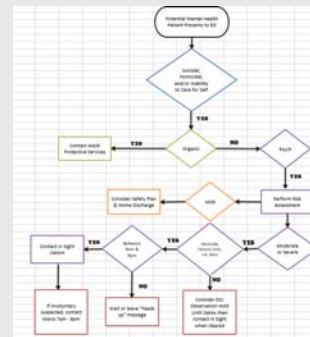



Not taking the time to use a value stream map or flowchart

Value Stream Map



Flowchart





Not following through





- The best way to lose:
 - Engagement
 - Trust
 - Credibility
 - Collaboration
 - Hope...why should we, it never changes

Not doing enough RCAs

- Why not? They really are quick and easy the more you practice
- Often lead to "Aha" moments
- Great visuals when paired with VSM or flowchart
- Going down the wrong road

But what about lack of training?
Leadership or management support?
Money

Is that your final answer??



Much, much, more

- Look up articles
- Find examples for you and your team
- Talk to your peers...external and internal
- Engage with your peers...go to conferences

Next Up

Date	Activity	Notes
January 19, 2022	Flex/HQIC Office Hours	Champions: Carly & Judy
February 14, 2022	QI Champions Education	Topics: Developing Driver Diagrams Communicating Data
February 16, 2022	Flex/HQIC Office Hours	Champions: Jarmila & Peggy
April 6-8, 2022	MHA Health Summit	No requirement, just opportunity. Do you have something you'd like to share? Short (QI Showcase) or Long (full session)
Anytime!	Schedule 1:1 Coaching	Contact Barb! 2 Hours Available for each participant!



Contact

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